HOUSE DOCKET, NO. 1404 FILED ON: 1/18/2023

HOUSE . . . . . No. 1215

The Commonwealth of Massachusetts

PRESENTED BY:

John J. Lawn, Jr.

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to pharmacy benefit managers.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
John J. Lawn, Jr.	*10th Middlesex*	*1/18/2023*
Steven Owens	*29th Middlesex*	*1/31/2023*
Michael J. Finn	*6th Hampden*	*1/31/2023*
Smitty Pignatelli	*3rd Berkshire*	*1/31/2023*
William J. Driscoll, Jr.	*7th Norfolk*	*1/31/2023*
Christopher Hendricks	*11th Bristol*	*1/31/2023*
Lindsay N. Sabadosa	*1st Hampshire*	*2/2/2023*
Vanna Howard	*17th Middlesex*	*2/2/2023*

HOUSE DOCKET, NO. 1404 FILED ON: 1/18/2023

HOUSE . . . . . No. 1215

By Representative Lawn of Watertown, a petition (accompanied by bill, House, No. 1215) of John J. Lawn, Jr. and others relative to pharmacy benefit managers. Health Care Financing.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act relative to pharmacy benefit managers.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Said section 1 of said chapter 6D , as so appearing, is hereby further amended by inserting after the definition of "Performance penalty" the following 2 definitions:-

"Pharmacy benefit manager", as defined in section 1 of chapter 176X

"Pharmacy benefit services", as defined in section 1 of chapter 176X

SECTION 2. Section 4 of said chapter 6D , as so appearing, is hereby amended by striking out, in lines 6 and 7, the word "manufacturers" and inserting in place thereof the following words:- pharmacy benefit managers.

SECTION 3. Section 6 of said chapter 6D , as so appearing, is hereby amended by adding the following paragraph:-

If the analysis of spending trends with respect to the pharmaceutical or biopharmaceutical products increases the expenses of the commission, the estimated increases in the commission's

expenses shall be assessed fully to pharmacy benefit managers in the same manner as the assessment pursuant to section 68 of chapter 118E. A pharmacy benefit manager that is a surcharge payor subject to the preceding paragraph and administers its own prescription drug, prescription device or pharmacist services or prescription drug and device and pharmacist services portion shall not be subject to additional assessment under this paragraph.

SECTION 4. Section 8 of said chapter 6D , as so appearing, is hereby amended by inserting after the word “organization” , in lines 6 and 7, the following words:- , pharmacy benefit manager.

SECTION 5. Said section 8 of said chapter 6D , as so appearing, is hereby further amended by inserting after the word “organizations”, in line 14, the following words:- , pharmacy benefit managers.

SECTION 6. Said section 8 of said chapter 6D , as so appearing, is hereby further amended by striking out, in lines 32 and 33 , the words “and (xi) any witness identified by the attorney general or the center” and inserting in place thereof the following words:- (xi) 2 pharmacy benefit managers; and (xii) any witness identified by the attorney general or the center.

SECTION 7. Subsection (g) of said section 8 of said chapter 6D , as so appearing, is hereby further amended by striking out the second sentence and inserting in place thereof the following sentence:- The report shall be based on the commission's analysis of information provided at the hearings by witnesses, providers, provider organizations, insurers and pharmacy benefit managers, registration data collected pursuant to section 11, data collected or analyzed by the center pursuant to sections 8, 9, 10,10A and 10B of chapter 12C and any other available

information that the commission considers necessary to fulfill its duties in this section, as defined in regulations promulgated by the commission.

SECTION 8. Section 9 of said chapter 6D , as so appearing, is hereby amended by inserting after the word “organization”, in line 72, the following words:- , pharmacy benefit manager.

SECTION 9. Said Section 9 of said chapter 6D , as so appearing, is hereby further amended by inserting after the word “organizations”, in line 82, the following words:- , pharmacy benefit manager.

SECTION 10. Section 1 of chapter 12C of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of “Patient-centered medical home” the following 5 definitions:-

“Pharmaceutical manufacturing company”, any entity engaged in the production, preparation, propagation, compounding, conversion or processing of prescription drugs, either directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided however, that “pharmaceutical manufacturing company” shall not include a wholesale drug distributor licensed pursuant to section 36A of chapter 112 or a retail pharmacist registered pursuant to section 38 of said chapter 112.

“Pharmacy benefit manager”, any person, business, or entity, however organized, that administers, either directly or through its subsidiaries, pharmacy benefit services for prescription

drugs and devices on behalf of health benefit plan sponsors, including, but not limited to, self-insured employers, insurance companies and labor unions;

"Pharmacy benefit services" shall include, but not be limited to, formulary administration; drug benefit design; pharmacy network contracting; pharmacy claims processing; mail and specialty drug pharmacy services; and cost containment, clinical, safety, and adherence programs for pharmacy services. For the purposes of this section, a health benefit plan that does not contract with a pharmacy benefit manager shall be a pharmacy benefit manager, unless specifically exempted.

"Wholesale acquisition cost", the cost of a prescription drug as defined in 42 U.S.C. §1395w-3a(c)(6)(B).

SECTION 11. Section 3 of said chapter 12C , as so appearing, is hereby amended by inserting after the word "organizations", in lines 13 and 14, the following words:- , pharmacy benefit managers.

SECTION 12. Section 5 of said chapter 12C , as so appearing, is hereby amended by inserting after the word "organizations", in line 11, the following words:- , pharmacy benefit managers.

SECTION 13. Said section 5 of said chapter 12C , as so appearing, is hereby further amended by inserting after the word "providers", in line 15, the following words:- , affected pharmacy benefit managers.

SECTION 14. Section 7 of said chapter 12C , as so appearing, is hereby further amended by adding the following paragraph:-

To the extent that the analysis and reporting activities pursuant to section 10A increases the expenses of the center, the estimated increase in the center's expenses shall be fully assessed to pharmacy benefit managers in the same manner as the assessment pursuant to section 68 of chapter 118E.

SECTION 15. Said chapter 12C is hereby further amended by inserting after section 10 the following section:-

Section 10A . The center shall promulgate regulations necessary to ensure the uniform analysis of information regarding pharmacy benefit managers that enables the center to analyze: (1) year-over-year wholesale acquisition cost changes; (2) year-over-year trends in formulary, maximum allowable costs list and cost-sharing design, including the establishment and management of specialty product lists; (3) aggregate information regarding discounts, utilizations limits, rebates, manufacturer administrative fees and other financial incentives or concessions related to pharmaceutical products or formulary programs; (4) information regarding the aggregate amount of payments made to pharmacies owned or controlled by the pharmacy benefit managers and the aggregate amount of payments made to pharmacies that are not owned or controlled by the pharmacy benefit managers; and (5) additional information deemed reasonable and necessary by the center as set forth in the center's regulations.

SECTION 16. Section 11 of said chapter 12C , as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:-

The center shall ensure the timely reporting of information required pursuant to sections 8, 9, 10 and 10A.

SECTION 17. Said section 11 of said chapter 12C , as so appearing, is hereby further amended by striking out, in line 11, the figure “$1,000” and inserting in place thereof the following figure:- $5,000.

SECTION 18. Said section 11 of said chapter 12C , as so appearing, is hereby further amended by striking out, in line 16, the figure “$50,000” and inserting in place thereof the following figure:- $200,000.

SECTION 19. Section 12 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 2, the words “9 and 10” and inserting in place thereof the following words:- 9, 10 and 10A

SECTION 20. Subsection (a) of section 16 of said chapter 12C , as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- The center shall publish an annual report based on the information submitted pursuant to sections 8, 9, 10, 10A and 10B concerning health care provider, provider organization, pharmacy benefit manager and private and public health care payer costs and cost and price trends, pursuant to section 13 of chapter 6D relative to market impact reviews and pursuant to section 15 relative to quality data.

SECTION 21. Chapter 94C is hereby further amended by inserting after section 21B the following section:-

Section 21C. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Cost sharing", amounts owed by a consumer under the terms of the consumer's health benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit manager as defined in section 1 of chapter 6D.

"Pharmacy retail price", the amount an individual would pay for a prescription medication at a pharmacy if the individual purchased that prescription medication at that pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any other prescription medication benefit or discount.

"Registered pharmacist", a pharmacist who holds a valid certificate of registration issued by the board of registration in pharmacy pursuant to section 24 of chapter 112.

(b) A pharmacy shall post a notice informing consumers that a consumer may request, at the point of sale, the current pharmacy retail price for each prescription medication the consumer intends to purchase. If the consumer's cost-sharing amount for a prescription medication exceeds the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient's cost-sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount or the current pharmacy retail price for that prescription medication, as directed by the consumer.

A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or a third party for failure to comply with this section.

(c) A contractual obligation shall not prohibit a pharmacist from complying with this section; provided however, that a pharmacist shall submit a claim to the consumer's health benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the prescription medication is covered under the consumer's health benefit plan.

(d) Failure to post notice pursuant to subsection (b) shall be an unfair or deceptive act of practice under chapter 93A.

SECTION 22 Section 226 of chapter 175 is hereby repealed.

SECTION 23. The General Laws are hereby amended by inserting after Chapter 176W the following chapter:-

Chapter 176X

Section 1 . As used in this chapter, the following words shall have the following meanings, unless the context clearly requires otherwise:-

“Carrier”, as defined in section 1 of chapter 176O “Commissioner”, the commissioner of the division of insurance.

“Cost-sharing requirement”, any copayment, coinsurance, deductible, or annual limitation on cost-sharing (including a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an insured in order to receive specific health care services, including a prescription drug, covered by a health benefit plan .

“Division”, the division of insurance.

“Health benefit plan”, as defined in section 1 of chapter 176O

“Health care services”, supplies, care and services of a medical, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive, or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services, services provided by a community health center or by a sanatorium, as

included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

“Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under other provisions of this chapter.

“Mail order pharmacy”, a pharmacy whose primary business is to receive prescriptions by mail, telefax or through electronic submissions and to dispense medication to insureds through the use of the United States mail or other common or contract carrier services and that provides any consultation with patients electronically rather than face to face.“Network”, as defined in section 1 of chapter 176O.

“Network pharmacy”, a retail or other licensed pharmacy provider that contracts with a pharmacy benefit manager.

“Person”, a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government or governmental subdivision or agency.

“Pharmacy”, a facility, either physical or electronic, under the direction or supervision of a registered pharmacist which is authorized to dispense prescription drugs and has entered into a network contract with a pharmacy benefit manager or a carrier.

“Pharmacy benefit manager”, a person, business, or other entity that, pursuant to a contract or under an employment relationship with a carrier, a self-insurance plan, or other third-

party payer, either directly or through an intermediary, manages the prescription drug coverage provided by the carrier, self-insurance plan, or other third-party payer including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

"Pharmacy benefit services" shall include, but not be limited to, formulary administration; drug benefit design; pharmacy network contracting; pharmacy claims processing; mail and specialty drug pharmacy services; and cost containment, clinical, safety, adherence programs for pharmacy services, and any other pharmacy benefit service that the commissioner deems appropriate. For the purposes of the chapter, a health benefit plan that does not contract with a pharmacy benefit manager shall be a pharmacy benefit manager.

"Rebates or fees", all fees or price concessions paid by a manufacturer to a pharmacy benefit manager or carrier, including rebates, discounts, and other price concessions that are based on actual or estimated utilization of a prescription drug. Rebates also include price concessions based on the effectiveness a drug as in a value-based or performance-based contract.

"Retail pharmacy", as defined in section 39D of chapter 112.

"Spread pricing" means the practice of a pharmacy benefit manager retaining an additional amount of money in addition to the amount paid to the pharmacy to fill a prescription.

"Steering", a practice employed by a pharmacy benefit manager or carrier that channels a prescription to a pharmacy in which a pharmacy benefit manager or carrier has an ownership interest, and includes but is not limited to retail, mail-order, or specialty pharmacies.

Section 2. (a) Any pharmacy benefit manager contracting with a pharmacy that operates in the commonwealth shall comply with the provisions of this chapter.

(b) A pharmacy benefit manager shall receive a license from the division before conducting business in the commonwealth. A license granted pursuant to this section is not transferable.

(c) A license may be granted only when the division is satisfied that the entity possesses the necessary organization, background expertise, and financial integrity to supply the services sought to be offered.

(d) The division may issue a license subject to restrictions or limitations upon the authorization, including the type of services that may be supplied or the activities in which the entity may be engaged.

(e) A license shall be valid for a period of three years. The commissioner shall charge application and renewal fees in the amount of $25,000

(f) The division shall develop an application for licensure that includes at least the following information: (i) the name of the pharmacy benefit manager; (ii) the address and contact telephone number for the pharmacy benefit manager; (iii) the name and address of the pharmacy benefit manager's agent for service of process in the commonwealth; (iv) the name and address of each person beneficially interested in the pharmacy benefit manager; and (v) the name and address of each person with management or control over the pharmacy benefit manager.

(g) The division may suspend, revoke, or place on probation a pharmacy benefit manager license under any of the following circumstances: (i) the pharmacy benefit manager has engaged

in fraudulent activity that constitutes a violation of state or federal law; (ii) the division received consumer complaints that justify an action under this chapter to protect the safety and interests of consumers; (iii) the pharmacy benefit manager fails to pay an application fee for the license; or (iv) the pharmacy benefit manager fails to comply with a requirement set forth in this chapter.

(h) If an entity performs the functions of pharmacy benefit manager acts without registering, it will be subject to a fine of $5,000 per day for the period they are found to be in violation.

Section 3

(a) (i) The pharmacy benefit manager shall have a duty and obligation to perform pharmacy benefit services with care, skill, prudence, diligence, and professionalism.

(ii) In addition to the duties as may be prescribed by regulation:

(1) A pharmacy benefit manager interacting with a covered individual shall have the same duty to a covered individual as the health plan for whom it is performing pharmacy benefit services.

(2) A pharmacy benefit manager shall have a duty of good faith and fair dealing with all parties, including but not limited to covered individuals and pharmacies, with whom it interacts in the performance of pharmacy benefit services.

Section 4

(a) A pharmacy benefit manager shall provide a reasonably adequate and accessible pharmacy benefit manager network for the provision of prescription drugs, which provides for convenient patient access to pharmacies within a reasonable distance from a patient’s residence.

(b) A pharmacy benefit manager may not deny a pharmacy the opportunity to participate in a pharmacy benefit manager network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the pharmacy benefit manager has established for other pharmacies as a condition of preferred network participation status.

(c) A mail-order pharmacy shall not be included in the calculations for determining pharmacy benefit manager network adequacy under this section.

Section 5.

(a) After the date of receipt of a clean claim for payment made by a pharmacy, a pharmacy benefit manager shall not retroactively reduce payment on the claim, either directly or indirectly, through aggregated effective rate, direct or indirect remuneration, quality assurance program or otherwise, except if the claim is found not to be a clean claim during the course of a routine audit performed pursuant to an agreement between the pharmacy benefit manager and the pharmacy. When a pharmacy adjudicates a claim at the point of sale, the reimbursement amount provided to the pharmacy by the pharmacy benefit manager shall constitute a final reimbursement amount. Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a contract between the pharmacy benefit manager or a pharmacy.

(b) For the purpose of this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstance requiring special treatment, including, but not limited to, those listed in subsection (d) of this section, that prevents timely payment from being made on the claim.

(c) A pharmacy benefit manager shall not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid unless the recoupment is:

(1) otherwise permitted or required by law; or

(2) the result of an audit, performed pursuant to a contract between the pharmacy benefit manager and the pharmacy; or

(d) The provisions of this section shall not apply to an investigative audit of pharmacy records when:

(1) fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or

(2) other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.

(e) No pharmacy benefit manager shall charge or collect from an individual a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid. If an individual pays a copayment, the pharmacy shall retain the adjudicated costs and the pharmacy benefit manager shall not redact or recoup the adjudicated cost.

Section 6.

(a) As used in this section:

(1) “Generically equivalent drug”, a drug that is pharmaceutically and therapeutically equivalent to the drug prescribed;

(2)(A) “Maximum allowable cost list”, a listing of drugs or other methodology used by a pharmacy benefit manager, directly or indirectly, setting the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product, or other prescription drug.

(B) Maximum allowable cost list includes without limitation:

(i) Average acquisition cost, including national average drug acquisition cost;

(ii) Average manufacturer price;

(iii) Average wholesale price;

(iv) Brand effective rate or generic effective rate;

(v) Discount indexing;

(vi) Federal upper limits;

(vii) Wholesale acquisition cost; and

(viii) Any other term that a pharmacy benefit manager or a carrier may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services;

(3) “Pharmaceutical wholesaler”, as defined in section 36A of chapter 112;

(4) “Pharmacist”, a pharmacist who, pursuant to the provisions of M.G.L. c. 112, § 24, is registered by the Board to practice pharmacy;

(5) “Pharmacist services”, products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy as defined in section 39D of chapter 112;

(6) “Pharmacy”, shall have the same meaning as defined in section 39D of chapter 112;

(7) “Pharmacy acquisition cost” means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice;

(8) “Pharmacy benefit manager”, as defined in section 1 of chapter 176X;

(9) “Pharmacy benefit manager affiliate”, a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager; and

(10) “Pharmacy benefit plan or program”, a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in the commonwealth.

(b) Before a pharmacy benefit manager places or continues a particular drug on a maximum allowable cost list, the drug:

(1) If the drug is a generically equivalent drug, it shall be listed as therapeutically equivalent and pharmaceutically equivalent A or B rated in the United States Food and Drug Administration's most recent version of the Orange Book or Green Book or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;

(2) Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in the commonwealth; and

(3) Shall not be obsolete.

(c) A pharmacy benefit manager shall:

(1) Provide access to its maximum allowable cost list to each pharmacy subject to the maximum allowable cost list;

(2) Update its maximum allowable cost list on a timely basis, but in no event longer than seven (7) calendar days from an increase of ten per cent or more in the pharmacy acquisition cost from sixty per cent or more of the pharmaceutical wholesalers doing business in the state or a change in the methodology on which the maximum allowable cost list is based or in the value of a variable involved in the methodology;

(3) Provide a process for each pharmacy subject to the maximum allowable cost list to receive prompt notification of an update to the maximum allowable cost list; and

(4)(A)(i) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable cost list and reimbursements made under a maximum allowable cost list for a specific drug or drugs as:

(a) Not meeting the requirements of this section; or

(b) Being below the pharmacy acquisition cost.

(ii) The reasonable administrative appeal procedure shall include the following:

(a) A dedicated telephone number, email address, and website for the purpose of submitting administrative appeals;

(b) The ability to submit an administrative appeal directly to the pharmacy benefit manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization; and

(c) No less than thirty business days to file an administrative appeal.

(B) The pharmacy benefit manager shall respond to the challenge under subdivision (c)(4)(A) of this section within thirty business days after receipt of the challenge.

(C) If a challenge is made under subdivision (c)(4)(A) of this section, the pharmacy benefit manager shall within thirty business days after receipt of the challenge either:

(i) If the appeal is upheld:

(a) Make the change in the maximum allowable cost list payment to at least the pharmacy acquisition cost;

(b) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;

(c) Provide the National Drug Code that the increase or change is based on to the pharmacy or pharmacist; and

(d) Make the change under subdivision (c)(4)(C)(i)(a) of this section effective for each similarly situated pharmacy as defined by the payor subject to the maximum allowable cost list;

(ii) If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in the

commonwealth that have the drug currently in stock at a price below the maximum allowable cost as listed on the maximum allowable cost list; or

(iii) If the National Drug Code provided by the pharmacy benefit manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefit manager shall adjust the maximum allowable cost as listed on the maximum allowable cost list above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost.

(d)(1) A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in the commonwealth an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services.

(2) The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.

(e) A pharmacy or pharmacist may decline to provide the pharmacist services to a patient or pharmacy benefit manager if, as a result of a maximum allowable cost list, a pharmacy or pharmacist is to be paid less than the pharmacy acquisition cost of the pharmacy providing pharmacist services.

(f) This section does not apply to a maximum allowable cost list maintained by MassHealth or the division of insurance.

(g)(1)A violation of this section shall constitute an unfair or deceptive act or practice pursuant to chapter 93A.

Section 7.

(a) No pharmacy benefit manager or representative of a pharmacy benefit manager shall conduct spread pricing in the commonwealth.

(b) A pharmacy benefit manager or representative of a pharmacy benefit manager that violates this section shall be subject to the surcharge under section 8 of chapter 176X.

(c) A pharmacy benefit manager shall report to the commissioner on a quarterly basis for each healthcare insurer the following information:

(A) The aggregate number of rebates received by the pharmacy benefit manager;

(B) The aggregate number of rebates distributed to the appropriate healthcare insurer;

(C) The aggregate number of rebates passed on to an insured of each healthcare insurer at the point of sale that reduced the insured's applicable deductible, copayment, coinsurance, or other cost-sharing amount;

(D) The individual and aggregate amount paid by the healthcare insurer to the pharmacy benefit manager for pharmacist services itemized by pharmacy, by product, and by goods and services; and

(E) The individual and aggregate amount a pharmacy benefit manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.

(d) The commissioner, in consultation with the health policy commission and the center for health information and analysis, shall annually report on the rebates and amounts reported under subsection (c), which shall be public record.

Section 8.

(a) A pharmacy benefits manager that engages in the practices of (i) spread pricing; (ii) steering; or (iii) imposing point-of-sale fees or retroactive fees shall be subject to a surcharge payable to the division of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs in the commonwealth.

(b) By March 1 of each year, a pharmacy benefit manager shall provide a letter to the commissioner attesting as to whether or not, in the previous calendar year, it engaged in the any of the practices under subsection (a). The pharmacy benefit manager shall also submit to the commissioner, in a form and manner and by a date specified by the commissioner, data detailing all prescription drug claims it administered in the commonwealth for insured residents on behalf of each health plan client and any other data the commissioner deems necessary to evaluate whether a pharmacy benefit manager may be engaged in any of the practices under subsection (a)

(c) By April 1 of each year, a pharmacy benefit manager shall pay into the general fund the surcharge owed, if any, as contained in the report submitted pursuant to subsection (b) of this section.

(d) Nothing in this section shall be construed to authorize the practices of steering or imposing point-of-sale fees or retroactive fees where otherwise prohibited by law.

(e) The commissioner, in consultation with the health policy commission and the center for health information and analysis, shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting pharmacy benefit manager with the total sum due to the commonwealth, which shall be public record.

Section 9.

(a) Any person operating a health plan whose contracted pharmacy benefits manager engages in the practices of (i) spread pricing; (ii) steering; or (iii) imposing point-of-sale fees or retroactive fees in connection with its health plans shall be subject to a surcharge payable to the division of 10 percent on the aggregate dollar amount its pharmacy benefit manager reimbursed pharmacies on its behalf in the previous calendar year for prescription drugs in the commonwealth.

(b) By March 1 of each year, any person operating a health plan and licensed in the commonwealth that utilizes a contracted pharmacy benefit manager shall provide a letter to the commissioner attesting as to whether or not, in the previous calendar year, its contracted pharmacy benefit manager engaged in any of the practices under subsection (a) in connection with its health plans. The health plan shall also submit to the commissioner, in a form and manner and by a date specified by the commissioner, data detailing all prescription drug claims its contracted pharmacy benefit manager administered in the commonwealth for insured residents and any other data the commissioner deems necessary to evaluate whether a health plan's pharmacy benefit manager may be engaged in any of the practices under subsection (a).

(c) By April 1 of each year, any person operating a health plan and licensed under this title shall pay into the general fund the surcharge owed, if any, as contained in the report submitted pursuant to subsection (b) of this section.

(d) Nothing in this section shall be construed to authorize the practices of steering or imposing point-of-sale fees or retroactive fees where otherwise prohibited by law.

(e) The commissioner, in consultation with the health policy commission and the center for health information and analysis, shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting health plan along with the total sum due to the commonwealth, which shall be public record.

Section 10.

When calculating an insured's contribution to any applicable cost sharing requirement, a pharmacy benefit manager shall include any cost-sharing amounts paid by the insured or on behalf of the insured by another person.

Section 11.

(a) A pharmacy benefit manager shall conduct an audit of the records of a pharmacy in accordance with paragraphs (1) to (13), inclusive.

(1) The contract between a pharmacy and a pharmacy benefit manager shall identify and describe the audit procedures in detail.

(2) With the exception of an investigative fraud audit, the auditor shall give the pharmacy written notice at least 2 weeks prior to conducting the initial on-site audit for each audit cycle.

(3) A pharmacy benefit manager shall not audit claims beyond 2 years prior to the date of audit.

(4) The auditor shall not interfere with the delivery of pharmacist services to a patient and shall make a reasonable effort to minimize the inconvenience and disruption to the pharmacy operations during the audit process.

(5) Any audit that involves clinical or professional judgment shall be conducted by, or in consultation with, a licensed pharmacist from any state.

(6) A finding of an overpayment or underpayment shall be based on the actual overpayment or underpayment. A statistically sound calculation for overpayment or underpayment may be used to determine recoupment as part of a settlement as agreed to by the pharmacy.

(7) The auditor shall audit each pharmacy under the same standards and parameters with which they audit other similarly situated pharmacies.

(8) An audit shall not be initiated or scheduled during the first 5 calendar days of any month for any pharmacy that averages more than 600 prescriptions per week without the pharmacy's consent.

(9) A preliminary audit report shall be delivered to the pharmacy not later than 30 days after the conclusion of the audit.

(10) The preliminary audit report shall be signed and shall include the signature of any pharmacist participating in the audit.

(11) A pharmacy benefit manager shall not withhold payment to a pharmacy for reimbursement claims as a means to recoup money until after the final internal disposition of an audit, including the appeals process, as provided in subsection (b), unless fraud or misrepresentation is reasonably suspected or the discrepant amount exceeds $15,000.

(12) The auditor shall provide a copy of the final audit report to the pharmacy and plan sponsor within 30 days following the pharmacy's receipt of the signed preliminary audit report or the completion of the appeals process, as provided in subsection (b), whichever is later.

(13) No auditing company or agent shall receive payment based upon a percentage of the amount recovered or other financial incentive tied to the findings of the audit.

(b)(1) Each auditor shall establish an appeals process under which a pharmacy may appeal findings in a preliminary audit.

(2) To appeal a finding, a pharmacy may use the records of a hospital, physician, or other authorized prescriber to validate the record with respect to orders or refills of prescription drugs or devices.

(3) A pharmacy shall have 30 days to appeal any discrepancy found during the preliminary audit.

(4) The National Council for Prescription Drug Programs or any other recognized national industry standard shall be used to evaluate claims submission and product size disputes.

(5) If an audit results in the identification of any clerical or record-keeping errors in a required document or record, the pharmacy shall not be subject to recoupment of funds by the pharmacy benefit manager; provided, that the pharmacy may provide proof that the patient

received the medication billed to the plan via patient signature logs or other acceptable methods, unless there is financial harm to the plan or errors that exceed the normal course of business.

(c) This section shall not apply to any audit or investigation of a pharmacy that involves potential fraud, willful misrepresentation or abuse, including, but not limited to, investigative audits or any other statutory or regulatory provision which authorizes investigations relating to insurance fraud.

(d) This section shall not apply to a public health care payer, as defined in section 1 of chapter 12C.

(e) The commissioner shall promulgate regulations to enforce this section.

Section 12.

(a) The commissioner may make an examination of the affairs of a Pharmacy Benefit Manager when the commissioner deems prudent but not less frequently than once every 3 years. The focus of the examination shall be to ensure that a pharmacy benefit manager is able to meet its responsibilities under contracts with licensed carriers. The examination shall be conducted according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(b) The commissioner, a deputy or an examiner may conduct an on-site examination of each pharmacy benefit manager in the commonwealth to thoroughly inspect and examine its affairs.

(c) The charge for each such examination shall be determined annually according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(d) Not later than 60 days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the pharmacy benefit manager examined with a notice which shall afford the pharmacy benefit manager examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall consider and review the reports together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

(i) adopting the examination report as filed with modifications or corrections and, if the examination report reveals that the pharmacy benefit manager is operating in violation of this section or any regulation or prior order of the commissioner, the commissioner may order the pharmacy benefit manager to take any action the commissioner considered necessary and appropriate to cure such violation;

(ii) rejecting the examination report with directions to examiners to reopen the examination for the purposes of obtaining additional data, documentation or information and re-filing pursuant to the above provisions; or

(iii) calling for an investigatory hearing with no less than 20 days' notice to the pharmacy benefit manager for purposes of obtaining additional documentation, data, information and testimony.

(e) Notwithstanding any general or special law to the contrary, including clause 26 of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other

inspection and the information contained in the records, reports or books of any pharmacy benefit manager examined pursuant to this section shall be confidential and open only to the inspection of the commissioner, or the examiners and assistants. Access to such confidential material may be granted by the commissioner to law enforcement officials of the commonwealth or any other state or agency of the federal government at any time, so long as the agency or office receiving the information agrees in writing to keep such material confidential. Nothing herein shall be construed to prohibit the required production of such records, and information contained in the reports of such company or organization before any court of the commonwealth or any master or auditor appointed by any such court, in any criminal or civil proceeding, affecting such pharmacy benefit manager, its officers, partners, directors or employees. The final report of any such audit, examination or any other inspection by or on behalf of the division of insurance shall be a public record.

Section 13.

A pharmacy benefit manager shall be required to submit to periodic audits by a licensed carrier if the pharmacy benefit manager has entered into a contract with the carrier to provide pharmacy benefits to the carrier or its members. The commissioner shall direct or provide specifications for such audits

Section 14.

(a) A contract between a pharmacy benefit manager and a participating pharmacy or pharmacist or contracting agent shall not include any provision that prohibits, restricts, or limits a pharmacist or contracting agent or pharmacy’s right to provide an insured with information on the amount of the insured's cost share for such insured's prescription drug and the clinical

efficacy of a more affordable alternative drug if one is available. Neither a pharmacy nor a pharmacist shall be penalized by a pharmacy benefit manager for disclosing such information to an insured or for selling to an insured a more affordable alternative if one is available.

(b) A pharmacy benefit manager shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including, without limitation, a fee for: (i) the receipt and processing of a pharmacy claim; (ii) the development or management of claims processing services in a pharmacy benefit manager network; or (iii) participation in a pharmacy benefit manager network, unless such fee is set out in a contract between the pharmacy benefit manager and the pharmacist or contracting agent or pharmacy.

(c) A contract between a pharmacy benefit manager and a participating pharmacy or pharmacist or contracting agent shall not include any provision that prohibits, restricts, or limits disclosure of information to the division deemed necessary by the division to ensure a pharmacy benefit manager's compliance with the requirements under this section or section 21C of chapter 94C.

SECTION 24. Sections 1 to 22 shall take effect 6 months after the effective date of this act.

SECTION 25. The commissioner of insurance shall promulgate regulations to implement chapter 176X of the General Laws, as inserted by section 23, not later than 1 year after the effective date of this act.